



GOVERNANCE FOR HUMAN RESOURCES IN HEALTH

CASESTORIES FROM AFRICAN COUNTRIES

Cordaid 

Colophon

© Cordaid, 2012

PO Box 16440

2500 BK The Hague

The Netherlands

www.cordaid.com

Text: Edited by Marjolein Dieleman KIT and Henriette Verbeem Cordaid

Photography: Wilco van Dijen, Mirjam Bleeker, Adriaan Backer, Cordaid

Cover and Design: Henriette Verbeem Cordaid, Forest&Bold

About Cordaid - The Catholic Organisation for Relief and Development Aid is a Dutch development agency operating worldwide, member of Cidse and Caritas Internationalis. We fight poverty and exclusion in fragile states, areas of conflict and extreme inequality. In order to stand up for the world's poorest and most marginalized communities, we raise funds in the Netherlands as well as internationally. Cordaid's main expertise lies in four fields of work: Conflict Transformation, Health and Well-being, Entrepreneurship and Disaster Risk Reduction & Emergency Aid. Cordaid works hand in hand with 890 partner organisations in 28 countries in Africa, Asia, the Middle East and Latin America for a more just and equitable global society.

All rights reserved. No part of this publication may be reproduced, translated, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without prior written permission from the publisher

Cordaid is a Catholic
Organisation for Relief
and Development Aid,
member of Cidse and
Caritas Internationalis.

TABLE OF CONTENTS

• Introduction	4
• Christian Social Services Commission (CSSC)	8
The contribution of Faith Bases Organisations to public health care provision in Tanzania <i>Marion Lieser</i>	
• NATIONAL ORGANISATION OF NURSES AND MIDWIVES (NONM)	13
Lobbying for scholarships for healthcare professionals in Malawi <i>Ben Phiri</i>	
• CIVIL SOCIETY FOR POVERTY REDUCTION (CSPR)	18
Community Budget Tracking and Service Delivery Monitoring in Zambia <i>William Chilufya</i>	
• NATIONAL CATHOLIC HEALTH SERVICES (NCHS)	24
Empowering Local Managers to Plan and Manage Healthwork in Ghana <i>George Adjei</i>	
• REGIONAL NETWORK ON EQUITY IN HEALTH IN EAST AND SOUTHERN AFRICA (EQUINET)	29
Lobbying at regional level. Institutional Collaboration on health workforce issues <i>Yoswa Dambisaya</i>	
• SOUTHERN AFRICAN NETWORK OF NURSES AND MIDWIVES (SANNAM)	34
The Role of Professional Organisations and Networks to Address the Human Resources for Health Situations: Advocating for nursing directorates in the SADC region <i>Philemon Ngomu</i>	
• WEMOS	39
Lobby for the Global Code of Practice on the International Recruitment of Health Personnel; an experience of Wemos. <i>Remco v.d. Pas</i>	
• Discussion	43

INTRODUCTION

Cordaid wants to ensure that we never stop learning from changes in the environment, results achieved, feedback from stakeholders, and the results of studies/research and evaluations. Linking and Learning (L&L) projects involve systematic teaching within a network of organisations. Partners are invited to participate in substantive exchanges and contribute to knowledge development and innovation.

The cases presented in this booklet represent the outcome of a Linking and Learning (L&L) path on Governance in the area of Human Resources for Health, initiated by Cordaid. The L&L path aimed to allow nine non state actors (civil society organizations and faith-based organisations), which are southern partners of Cordaid, to learn from each others' experiences in influencing Human Resource of Health policy formulation and implementation. Each participating organization has written a case story about relevant experiences and all these case stories were exchanged and discussed. Seven case stories are presented here.

CSOs have a role in policy influencing. In the case of good existing public policies, CSOs have a role in ensuring stakeholder participation, and holding the government accountable for correct implementation of their policies. Communities of Change bring stakeholders together, including government officials. CoCs provide a good mechanism for improvement of good governance in a country.

The L&L path was facilitated by Cordaid and two senior advisors from the Royal Tropical Institute in Amsterdam (KIT), through a workshop, online guidance in the development of case stories and being the main authors for the introduction and discussion section of this booklet .

We would like to thank the auditors Marion Lieser (Christian Social Service Commission), Ben Phiri (Nurses and Midwives Organization of Malawi), William Chilufya (CSRP Zambia), George Adjei (National Catholic Health Services. Ghana), Yoswa Dambisaya (EQUINET/ South Africa), Philemon Ngomu (Southern Africa Nurses and Midwives Network) and Remco v.d. Pas (Wemos). Special thanks to Marjolein Dieleman from the Royal Tropical Institute in Amsterdam for all her editing and support. And also Jose Utera from Cordaid who was the responsible Program Officer of Cordaid during the project and Christina de Vries as supervisor.

Cordaid, The Hague, May 2012



NCHS



Christian Social Services Commission



Royal Tropical Institute
KIT Development Policy & Practice

BACKGROUND

According to the World Health Report 2006, 57 countries face a critical shortage of health workers. This affects the quality of care provided to populations, and progress towards achieving the Millenium Development Goals. In response to the critical workforce shortages, many institutes at national and international level have made efforts to address the shortage and performance of health workers. Among these actors are Cordaid and its partners, that identified the shortage of Human Resources for Health (HRH), especially in rural and underserved areas, as one core problem that impedes the delivery of quality health services to the population they work with.

Cordaid has been working for several years with African non state actors, such as Civil Society Organizations and Faith Based Organisations (FBOs), in the field of health. Many of the FBOs work mainly in service delivery to poor population in underserved areas, while the civil society organisations carry out capacity building of local organizations, and advocate and lobby for improvement of access of vulnerable and marginalized groups to health services.

In the last years several African countries have formulated national Human Resources policies for the Health sector. However, often Cordaid received remarks from its partners that Human Resources for Health policies do not sufficiently take into account the interests and needs of different stakeholders, such as professional associations, the FBO's and in particular the needs of marginalised and vulnerable groups. Poor governance at different decision making levels has been identified by Cordaid partners as one of the underlying reasons.

Although the need for qualified and sufficient human resources for health has been addressed in various published studies and interventions, the role of governance in human resources for health has received less attention in literature. Several definitions exist for governance, and for this exchange, partners have agreed upon the definition of governance of Brinkerhoff and Bossert (2008): *"Governance is about the rules that distribute roles and responsibilities among government, providers and beneficiaries and that shape the interactions among them. Governance encompasses authority, power, and decision making in the institutional arenas of civil society, politics, policy, and public administration"*.

In the field of Health Work Forces, poor governance leads, amongst others, to poor Human Resource for Health policy formulation and implementation. An example of how governance in these policies can have a negative impact on the implementation of Human Resource for Health strategies is provided in box 1.

Box 1: Example of poor governance

A Faith-Based Organisation in Uganda intended to increase access to pharmaceutical services by shifting tasks to lower level cadres who were present at clinics in underserved areas, but professional associations and professional councils blocked this process as they were not involved in the decision-making process (Adjei et al, 2009). Responding to such dilemmas requires attention to governance, in this case partnerships, in the formulation and implementation of Human Resource for Health policies.

Governance is complex, as HRH policy formulation and implementation has a multitude of actors. For instance:

- On the government side, different ministries are involved, for instance: the ministry of finances deciding on the financial resources available for the implementation of policies; the ministry of health deciding on the quantity, quality and distribution of the human resources; the ministry of education deciding on the educational requirements and plans for the production of the human resources; and the ministry of labour/ civil service commission) deciding on the regulations related to remuneration, working conditions and provisions for the health workers. In addition, in decentralized countries, local governments play a role in hiring and firing of health workers
- The service delivery organisations play a role in the management, motivation and working conditions of the health workers;
- The councils and professional associations represent the interests of their members and set standards for quality of their profession; the labour unions are interested in the working conditions of its members;
- Health insurers, consumer/ patient organisations are interested in good quality services (from a providers and consumers perspective)

To better understand the issues at stake when discussing governance, the concept of governance can be divided into four overarching dimensions (Dieleman and Hilhorst 2008).

- The first dimension is performance, which concerns the efficiency/ effectiveness of Human Resource for Health policies and plans.
- A second dimension is equity and equality in Human Resource for Health policy formulation and implementation, in other words, whether the needs of different groups in the community and health workers are equitably addressed by Human Resource for Health policies and are inclusive.
- A third dimension concerns partnerships, or having a level-

playing field in which groups with different interests and roles have an opportunity to participate.

- The fourth and last dimension is oversight. Oversight includes rule of law and accountability. An accountable relationship is one in which duty bearers (such as leaders or service providers) are obliged to account for and take responsibility for their actions, while rights holders (citizens or clients) are able to hold these duty bearers to account.

Table 1 provides an overview of how different components that are described in articles on governance in the field of HRH, can be regrouped into these four dimensions.

Performance	Efficiency and effectiveness, capacity to implement
	Ethics and respect (incl. for citizens)
	Intelligence, information, evidence, m&e
	Policy objectives vs. Organizational structure capacity to implement, decentralization
	Strategic vision, leadership, direction, decision-making process
Equity and equality	Fairness, equity, inclusiveness responsiveness
Partnerships and participation	Consensus orientation, coalition, partnership
	Legitimacy, voice, participation
Oversight	Accountability
	Regulation
	Rule of law, enforcement (incl. corruption control)
	Transparency

Governance for Human Resource for Health policy formulation and implementation takes place at there different levels, which have at each level different stakeholders:

1. Global level, governance issues dealt with at global level are for instance setting goals and determining resource needs for priority programs such as TB, Malaria and HIV/AIDS. These are often negotiated at global level and have work-force implications at national level. This is also the case with regulation of the labour market which is globalised.
2. National level- for national Human Resource for Health plans to assure that sufficient and qualified and motivated health workers are available in all areas in the country
3. Local level, to improve quality of care at facility level, in which managers, health workers, local governments and consumers have a direct stake.

The 7 case stories presented here show the efforts of civil society organizations to address governance in Human Resource for Health. These case stories are categorized according to the four dimensions of governance. Four cases address efficiency/

effectiveness of Human Resource for Health policies and plans; performance. The case story of WEMOS presents an effort to improve the implementation of the global code of practice on the international recruitment of health personnel through international lobbying. The National Catholic Health Serviced (NCHS) in Ghana aims to help hospitals develop Human Resource for Health strategic plans by organizing write shops for local hospital managers and the case story of National Organisation of Nurses and Midwives (NONM) in Malawi presents an effort to influence national policies to keep the provision of scholarships for student nurses in their plans. The collective of nurses and midwives (SANNAM) in South Africa strives for better Human Resource for Health policies and hence improved working conditions for nurses and midwives in the region by lobbying for a Directorate for Nursing, so as to allow inclusion of nurses' interests in formulation of Human Resource for Health plans. These efforts aimed at improving the efficiency and effectiveness of Human Resource for Health policies show us the importance of having various stakeholders influencing the policy-making process to make sure that different interests are taken into consideration.

One case looks at ways to improve accountability: The case story of Civil Society for Poverty Reduction (CSPR) in Zambia presents an effort to improve accountability at local level. Communities are involved in public service delivery to increase the ownership, voicing and empowerment of citizens in planning, implementing and monitoring health service delivery, including performance of health workers.

And lastly, two case stories focus on partnerships, to have a level-playing field in which groups with different interests and different roles have an opportunity to participate. Christian Social Services Commission (CSSC) in Tanzania describes a service agreement between local government authorities and health facilities, with the aim to enhance the provision of quality social services in rural areas. EQUINET (Regional Network on Equity in Health in East and Southern Africa) and ECSA HC (East, Central and outhern African Health Community) case provides an interesting effort where two organizations work together to complement each other at regional level: Equinet provides evidence that ECSA HC uses for lobbying and advocacy in the area of HRH.

The case stories that are presented reflect some of the practices that CSO's including FBOs have implemented. These stories are not just illustrations of efforts to improve Human Resource for Health policy formulation and implementation at different levels, but can also be used as a starting point for discussions on CSO and FBO involvement in Human Resource for Health planning and development at international, national and local level. To stimulate such discussions, we have

formulated questions at the end of each case story as a guidance for a discussion.

References

- Adjei, G.A., Maniple, E.B., Dokotola, T.B., Kahabi, J., Mpooza, I.K., Pamba, P.M., Pearl, E. (2009), *Quest for quality: Interventions to improve human resources for health among faith-based organizations*, edited by Dieleman, M. and Hilhorst, T., The Hague: Cordaid.
- Brinkerhoff D.W., Bossert, T.J. (2008), *Health governance: Concepts, experience, and programming options*, Washington: USAID.
- Dieleman, M., Hilhorst, T. (2008), *Improving human resources for health: Turning attention to governance*, Concept note.
- World Health Organization (2006), *The world health report 2006: Working together for health*, Geneva: WHO

Casestudy

Christian Social Services Commission (CSSC)

The contribution of Faith Bases Organisations to public health care
provision in Tanzania

Marion Lieser





INTRODUCTION

Socioeconomic and Political Context

Tanzania is a multi-party democratic country with its administration based on a President, Parliament and Judiciary Branch. Tanzania has 26 administrative regions and 130 administrative districts. About 80% of Tanzanians live in rural communities. According to the United Nations (2009), the size of the population has reached 43.7 million. Governance in all sectors has been decentralised to the districts, with the central government playing a policymaking and oversight role.

Today, Tanzania ranks in the bottom ten percent of the world's economies in terms of per capita income (GNI US\$ 440 according to the World Bank, 2008). Agriculture is the mainstay of the economy, accounting for about half the national income, three-quarters of merchandise exports, and as a source of food and employment for at least 80 percent of the population. Besides agriculture, trade, tourism and other service sectors are major contributors to economic growth in Tanzania¹.

Human Resource for Health Situation in Tanzania

Tanzania currently has 35,202 health workers, whereas the current number of health care facilities requires a total of 125,824 health workers, indicating a gap of 90,722 health workers (53,214 in the public sector and 37,508 in the private sector), or a staff shortage of 65% in the public sector and 86% in the private sector. The shortage of health workers is more pronounced in rural and hardship areas and among clinicians, nurses, midwives, laboratory and pharmaceutical technicians, health officers, and administrators.

JUSTIFICATION

Tanzania's health care service suffers from a chronic lack of resources, which leads to low quality health care and no access for many poor families. 40% of all health care services in the country are provided by Faith-Based Organisations (FBO's), organised within the framework of the Christian Social Services Commission. In rural areas health care provision is mainly offered by church-run facilities. In addition, the Human Resources for Health (HRH) crisis, with a deficit of more than 90,000 health workers, undermines efforts to improve service delivery.

Effective access to functioning, affordable, and efficient health care services is a prerequisite to improve the quality of life and to promote the well-being of all Tanzanians. This requires adequate human resources, and Tanzania faces challenges

to provide all this. Basic services are not available to a large number of people, particularly in rural areas, due to the lack of qualified HRH. Inadequate infrastructure links urban and rural areas, which is why rural areas have been denied many services, since placements there are not attractive and health workers can find occupation in better supplied, more urban areas.

The Government of Tanzania (GoT) realised it was able to provide health care services through its own resources, and teamed up with FBO's to improve the situation, with the ultimate aim of enhancing the provision of quality health care services in rural areas. The focus is to bring health care services closer to rural communities and to offer appropriate health education.

Therefore, after three years of intensive discussions with all stakeholders, CSSC developed a unique tool to assist the GoT's efforts to provide health care services to all. It avoids duplication of interventions and maximises the impact of donor support, through Service Agreements between health facilities and Local Government Authorities, which include and specifically address HRH.

OBJECTIVES

Core elements of CSSC's interventions aim to achieve that a fair share of the GoT's budget funding gets through the health basket to the facilities that are providing services (especially in remote areas), and this includes a) lobbying and advocacy, b) capacity building, c) fostering partnerships and networking, and d) institutional development. These elements are all of the utmost importance for reaching a successful Service Agreement.

One of the major and overall objectives of the Service Agreement tool is to apply this mechanism easily in order to increase national funding for FBO health care facilities. The purpose is to appropriately reflect the magnitude of their contribution to health care service delivery. At the same time, CSSC is increasing its overall influence on the GoT regarding the health care system. It lobbies so that FBO facilities can become professionally managed partners of the GoT, and enhances closer ties of the surrounding communities with decision making processes in order to improve service quality.

The goal is to improve health care services and make them accessible by allowing the FBO services to complement Tanzania's efforts on the national level. To achieve this, CSSC enters a Public Private Partnership between the church facilities and the GoT.

¹ <http://www.state.gov/r/pa/ei/bgn/2843.htm>

MAIN ACTIVITIES

With the support of various development partners, the GoT and others, CSSC developed the concept of a Service Agreement for the provision of quality health care services by FBO Health Providers (agreed in 2007). Through this agreement, the GoT expects that all members of communities will enjoy access to high quality medical care, including adequate Human Resources for Health. This is a contractual agreement between the GoT (Local Government Authorities) and service providers, and CSSC lobbies these parties so that they will sign them.

The Service Agreement defines:

- a) the duties and obligations of the GoT and the service provider
- b) the types of services involved
- c) the expected coverage and quality
- d) reimbursement arrangements, and
- e) the geographic area and contract period.

The Service Agreement also ensures the objective allocation of public resources to FBO service providers, and gives these providers a reliable source of income for quality service provision. The SA allows private providers to receive public funds in answer to their demands, and contributes to strengthening the cooperation between the Government of Tanzania and service providers. Ultimately, the SA increases the availability of affordable quality health care services to the general population.

Major activities include: raising the awareness of the Government of Tanzania authorities, local leaders, and surrounding communities regarding the SA; training FBO health care personnel and finance managers so that they are able to implement the SA; implementing a public relations (PR) strategy on health care expenditures and SA; distributing/ providing informational material on the importance of investing in health; and data collection, analysis, and policy formulation in support of the SA. CSSC's experience working with the Government of Tanzania, the private sector, and civil society contributes to the success of all major activities. The concept of the SA conforms to the National Strategy for Growth and Reduction of Poverty (NSGRP), which specifically favours Public Private Partnerships and rates them as one success factor for solving Tanzania's health workforce crisis.

PROCESS OF IMPLEMENTATION

During the implementation of the first 6 SA's, an increased knowledge among Local Government Authority representatives regarding the role of FBO's in health care service provision



resulted in less reluctance to support the facilities, and in more openness towards their work. Whenever necessary, discussions took place about increasing national funding for FBO facilities in proportion to the size of their contribution to health care. An improved data base on the facilities, their staffing situation, and budgetary needs feeds the discussions that aim at strengthening the FBO position. As one of the first steps in preparation of a Service Agreement, CSSC helps facilities to improve their financial management, thus enabling them to actually implement the SA. These are sustainable capacity building efforts that are beneficial to the facilities and the communities in the long term. By implementing SA's, CSSC is also in a better position to contribute at a national level to a more sustainable health care policy formulation.

Moreover, the lobbying and advocacy efforts of CSSC include its regular presence at the National and Council levels, organising and conducting awareness raising and informational meetings surrounding the SA, developing and disseminating SA details and the way they are administered, and making the concrete costs of services known to the FBO facilities to enable them to become a partner within the framework of a SA.

KEY ACHIEVEMENTS/ CHALLENGES

The improved environment that enhances the support of funding for the FBO health sector in Tanzania can be attributed to the CSSC's interventions and to the quality of the approaches at a rural level. In this case, regular meetings are held where all stakeholders on a zone level are brought together, e.g. in bi-annual Zonal Policy Fora, or at the Council level by contributing to the Comprehensive Council Health Plan (CCHP) development. The Government of Tanzania's sources depend on FBO facilities and their cooperation to keep its promise (as stated in

the Constitution) of providing health care services to the population.

To guarantee the achievement of the objectives described earlier, even in more difficult circumstances, a close interaction and linkage was established among authorities from the onset of the SA implementation.

A challenge faced by the Service Agreement is the change that is occurring in development cooperation, and the reduced funding for health interventions (e.g. most recently from the Netherlands). This threatens the success of the established SA's and the health service provision to rural areas through public outlets. Therefore, it is important to note that the CSSC approach complements public services and helps public entities to save funds and spend less and more efficiently, because they can concentrate on established facilities and don't need to upscale their own efforts. A SA helps the GoT realise better coverage and quality of services with a minimum of effort, rather than financing its own, new public structures.

The joint and transparent development of implementation details is therefore one top priority when executing the SA's.

CONCLUSIONS AND LESSONS LEARNED

The establishment of a constructive approach by the Christian Social Services Commission, featuring collaboration between all key stakeholders and promoting Public Private Partnerships within the Tanzanian health care system, created opportunities to address the HRH crisis and start solving it. Church health care service providers came together and consequently began stimulating the Local Government Authorities to acknowledge and integrate FBO health care services (including HRH development and planning) in their long term planning and budgeting. Likewise, the churches were recognised as being complementary, key partners within the public health care system.

This formalised SA partnership requires regular interaction among the partners involved, if one is to ensure its lasting success and the capacity building of the health care workforce in Tanzania in a reliable way. Moreover, through the SA's, CSSC is actively contributing to solve the Human Resources for Health crisis that the country faces.



Casestudy

National Organisation of Nurses and Midwives (NONM)

Lobbying for scholarships for healthcare professionals in Malawi

Ben Phiri





INTRODUCTION

The Human Resources for Health (HRH) coalition, which was established in 2009 in Malawi, is a coalition of professional, civil society, trade union, educational, and service provider organisations with the common interest of campaigning for HRH issues. Its members include: the National Organisation of Nurses and Midwives of Malawi (NONM), the Malawi Health Equity Network (MHEN), the Consumer Association of Malawi (CAMA), the College of Medicine, the Paramedical Association, the Malawi Congress of Trade Unions (MCTU), and the Christian Health Association of Malawi (CHAM). Representatives of relevant government institutions, such as the Ministry of Health, Ministry of Education, and Ministry of Labour, and representatives of international institutions and NGO's, such as GTZ, Médecins Sans Frontières Belgium – Malawi, and Norwegian Church Aid, participate in the coalition as (active) observers and advisors.

The members of the coalition are engaged in different aspects of HRH at different levels. This makes it possible for the coalition to take informed positions supported by several stakeholders and their constituencies. NONM, which is one of the founders and the leading organisation of the coalition, is a professional union representing the professional and socioeconomic interests of over 80% nurses and midwives in the country.

Advocates under the umbrella of the Human Resources for Health (HRH) coalition successfully lobbied government to reconsider providing scholarships to mid-level health care professionals in Malawi. The campaign was conducted from October, 2009 to July, 2010.

BACKGROUND

Health care workers are essential for the achievement of global and national social and development goals. Both the Millennium Development Goals (MDG's) and the Malawi Growth and Development Strategy (MGDS) recognise the role of skilled health care workers. However, the low supply of health care workers continues to hinder how quickly these development agendas are met. In Malawi, the Human Resources for Health situation is characterised by an acute shortage of health care workers; for example, the vacancy rate for nurses is 76%, while 1 nurse takes care of 3,038 people.

Over the years, the government and other players have taken steps to address the shortage of health care workers in Malawi. The Emergency Human Resources Programme (EHRP) is one such initiative. This six-year programme was designed in 2004.

One of the five elements of the programme was to increase the capacity to train eleven priority health care cadres by providing scholarships. As a result, the nursing/ midwifery graduates increased 22%, from 575 in 2004 to 699 in 2009.

One challenge the programme faced was a government decision taken in September, 2009 to stop scholarships for health care training. Government cited financial constraints as reasons for closing the programme. The decision led to student and public outcry. The HRH coalition considered it was important to help solve the fee crisis by advocating and lobbying with decision makers to reverse the decision and provide student health care professionals with scholarships for their training. Increased numbers of graduates would improve the staffing situation, which in turn would improve the poor's access to health care services.



ACTIVITIES

The fee campaign aimed at influencing the government to reconsider providing scholarships for the training of nurses/midwives and other mid-level health care professionals.

The process started with a consultation meeting amongst coalition members, student nurses and midwives, college authorities, and other professional and civil society organisations. The members of the coalition defined the coalition's position, analysed the problem, and formulated proposals for solutions, taking into consideration the opinions of its members. The outputs of the meeting were a campaign strategy, action plan, and position paper. These items contained the campaign objective, degree of the problem, and alternative solutions. The plan also included: target audience, allies, key messages and communication channels, sharing responsibilities, timescale, and resources. The tasks that each actor or group of actors would carry out were agreed upon.

The process of implementation involved capturing the evidence, communicating the message to targeted decision makers and the public, consultations, mobilisation meetings, presentation of the position paper, and lobbying at all levels.

The media publicised the campaign through both print and electronic sources. The position paper was published in the two popular daily papers, *Nation* and *Malawi News*. Live public debates and panel discussions were also conducted on the radio. Panellists came from the HRH coalition and allies. Listeners phoned in to give their opinions on the issue. Additionally, informational materials were produced, such as billboards, posters, leaflets, and the *Malawian Nurse* magazine.

The community was mobilised surrounding the issue across the country. Students from all nursing colleges marched to present the Position Paper to District Commissioners, Members of Parliament, chiefs and religious leaders in their communities. One parliamentarian even drafted a motion ready for presentation to parliament for introducing a fuel levy to fund health care professionals' training.

Capturing, analysing and presenting evidence was done through periodic situational analyses in the colleges to assess the gravity of the problem. EHRP draft evaluation reports provided additional data on the targeted enrolment figures. For instance, due to the lack of fees, only 87 out of the targeted 610 selected students had enrolled in school by January, 2010.

Lobbying and consultations were conducted at all levels. Meetings were held with Parliamentary Committees on Health,

Budget, and Finance. The parliamentarians showed commitment and signed pledge forms to support the fee issue in Parliament. The International Council of Nurses (ICN) wrote the Head of State requesting him to consider addressing the fee issue to improve the HRH situation in Malawi. As a result, the Chief Secretary to the President and Cabinet discussed the issue with NONM and gave assurance of the government's support.

Furthermore, alternative solutions were submitted to the Minister of Finance during pre budget consultations conducted across the country.

Monitoring was done through periodic coalition meetings held during the campaign period to measure progress and decide on the subsequent steps. Parliamentary discussions were observed during the budget session. The visibility of the campaign was monitored using media coverage.



ACHIEVEMENTS AND CHALLENGES

The ultimate result of the campaign is that the government reconsidered its decision on the fees. Parliament approved the 2010-2011 budget allocation to fund the training of nurses, midwives, and other health care professionals.

This achievement can be attributed to several factors. The first factor is the call for support from the student nurses/ midwives and their parents, which created a sense of urgency for intervention by the coalition. Second, clear planning for action with key players using multiple strategies such as coalition meetings, strategy, and position paper formulation was essential. Third, the commitment of the lead organisation, NONM, as well as other coalition organisations was important, as well as the solidarity shown by diverse allies such as local and international, faith-based, professional, and human rights organisations

and the media. In this campaign, the HRH coalition was able to engage advocacy institutions from diverse backgrounds to support its position, including: the Evangelical Association of Malawi, the Council for NGO's in Malawi, the Human Rights Consultative Committee, the Civil Liberties Committee, the Association of Malawian Midwives, the Evangelical Association of Malawi, and the Malawi Network of Religious Leaders on HIV/Aids. Other international allies included: the Norwegian Nurses Organisation, the Royal College of Nursing, and the Southern Africa Network of Nurses and Midwives.

CONCLUSIONS AND LESSONS LEARNED

It is possible to successfully lobby on complicated governance issues that affect health care, such as financing. Coordination amongst diverse organisations to struggle for a common cause, a strong lead organisation, mobilised beneficiaries, and support from allies and partners are vital for influencing policy making regarding key health care governance issues. Additionally, partnerships at all levels provide the synergy that leads to successful lobbying.

Advocates should be ready and prepared to face any unplanned HRH governance crises that require urgent interventions and a joint approach.

Finally, the external financial support provided by Cordaid enabled the coalition to effectively implement the plans.

Key challenges included the high expectations for finding quick solutions voiced by student nurses and midwives who phoned and wrote letters to NONM for support. Another challenge faced was the inadequate understanding some key stakeholders had concerning the motivations behind civil society's lobbying for Human Resources for Health. The Ministry of Health and some development partners indicated that NONM and the Human Resources for Health coalition had no reason for lobbying on the issue by citing the lack of funds mentioned in the EHRP evaluation.

At present, the coalition has established a minimal structure for functioning and has planned small research activities on which its views and positions can be founded, and which shall increase the advocacy and lobbying capacities of its members. Gradually the HRH coalition has acquired a relevant position to participate in HRH policy and programmatic discussions in the country. Some members of the coalition are also taking part in the National Technical Commission that advises the government in HRH issues, thus sharing the Community Service Organisation's views.

The Human Resources for Health Coalition in Malawi is a multi-stakeholder platform composed of several CSO's that work in health care, especially in issues related to HRH. Representatives of various government institutions involved with HRH also participate in this coalition. The coalition now occupies a significant position that enables it to engage in issues related to decision making regarding the health workforce issue in the country. It organised a successful campaign to ensure the continued training of a sufficient amount of health care professionals.

- Who are the main players in HRH policy and programmatic issues in your country? Would they be interested in forming a coalition?
- Do networks or a coalition of CSO's and other actors involved with HRH policy and programmatic issues exist in your country? If not, do you think it will be useful to establish such a coalition?
- Which activities might be coordinated in your country by a HRH coalition/ platform/ network of CSO's and other actors active in HRH?

Casestudy **Society for Poverty Reduction (CSPR)**

Community Budget Tracking and Service Delivery Monitoring in Zambia

William Chilufya





INTRODUCTION

The Civil Society for Poverty Reduction (CSPR) is a network of over 100 civil society organisations involved in the fight against poverty in Zambia. These organisations are primarily concerned with reducing poverty and its impact on vulnerable groups within Zambia through advocacy and lobbying with policy makers.

The National Budget is deemed by the CSPR as an important economic policy instrument, since adequate resource allocation to the social and health care sector can contribute to reducing poverty. Therefore, CSPR finds it imperative to undertake a budget analysis, including tracking and expenditure monitoring.

CSPR has introduced a new budget tracking system which involves the community: the Community Budget Tracking and Service Delivery Monitoring. The project is in its initial stages of implementation; consequently, no results can be shown yet. However, it is an initiative worth sharing.

COMMUNITY BUDGET TRACKING AND SERVICE DELIVERY MONITORING

CSPR's community budget initiative is a result of the implementation of Zambia's Fifth (and Sixth) National Development Plan. It is also based on the fact that, ultimately, the quality and quantity of public service delivered depends on good planning, proper financial management, accountability and transparency, and effective systems for monitoring results, among other things. However, the public service delivery sector has lacked the ownership, participation, voice, and empowerment of citizens in the planning, implementing, and monitoring processes. This view is based on an understanding that development results cannot be driven only from the core, but also need to be monitored through local efforts.

On this premise, CSPR has found among other things that it is imperative for locally based Civil Society Organisations (CSO's) and communities to participate in monitoring funds. This level of participation will help to guarantee more effectively that resources are used in the best interest of the poor. Second, CSO's and communities should enhance their participation in the Provincial Development Coordinating Committee, District Development Coordinating Committee, and Area Development Committee meetings. Through these meetings, CSO's and communities can lobby and work with the government in planning, implementing, and monitoring the national development policies.

The rationale behind the involvement of communities in this process is that:

- Local government is held accountable for its actions regarding both its service delivery and budget execution.
- Government must be monitored to ensure it does not abuse its power.
- Government must serve the public interest, particularly that of the poor in an efficient, effective and equitable manner.

It is against this background that CSPR has embarked on enhancing citizens' capacities, particularly at district and community levels, to participate in development processes. More specifically, CSPR is enhancing citizen awareness that the government should be held accountable for its execution of the National Budget and service delivery, and its ability to make the government act accordingly. In addition, CSPR is coordinating with civil society organisations and community groups in monitoring service delivery and budget execution. Emphasis is placed on the participation of citizens in the planning, monitoring and advocacy processes.

ATTENTION TO HEALTH CARE SERVICES

Included among the areas of budget monitoring and service delivery for the community is health care. Within the health care sector attention is given to Human Resources for Health (HRH).

The situation regarding the skilled human resources for health care still remains critical in Zambia. However the cabinet office has increased the approved number of positions, which now stands at 31,883. Clearly, issues of low pay and poor professional practice environments make it attractive for health staff to move away from the public health system, particularly in rural areas. In areas where cash incentive schemes have been applied for some time to medical doctors, the situation is showing some steady progress. This is not the case among the other cadres in the schemes that have been introduced recently (nurses, midwives, etc.). There are still many positions in the scheme that aren't included. According to the Ministry of Health, compared to approved and established positions, the shortfall of doctors and nurses is 46%, 60% for clinical officers, 53% for midwives, 74% for pharmacy staff, and 47% for Environmental Health Technicians (EHT's).

ACTIVITIES

The community budget tracking and service delivery monitoring project is active in five provinces in Zambia, namely, Eastern, Luapula, North-western, Southern, and Western provinces. These five provinces have been targeted as they are part of CSPR's area of operations. According to official statistics, these provinces are deemed to be the poorest in Zambia. Lusaka province will also be included in the project, but this will be limited only to activities at the macro level.

In each province, the action is taking place in two districts, comprising the provincial district headquarters and a rural district. The criterion for selecting these districts is based on having a representation of citizens from an urban district as well as a rural one. This enables capturing different dimensions of service delivery and the modalities of how resources are allocated and spent, in both remote districts and districts located close to the provincial administration.

In each district, one community is participating and undertaking service delivery and budget execution monitoring; this community is selected with due consultation with stakeholders. In total there are 10 communities. These communities were identified in Zambian provinces where CSPR works; the areas were selected on the basis of their high poverty levels.

To effectively ensure the participation of the communities in the project and the success of the exercise, people's cooperation is of the essence. To this effect, CSPR liaised with the local and traditional leaders, CSO's, and influential persons to select either existing community groups or to elect community members to participate in a community committee. A broad cross-section of the community is represented in this committee, which is composed of residents of the selected communities. The committees are gender-balanced (representation of both women and men as community members), with representation of special interest groups (the elderly, youth, women), including a few implementers which might eventually work as allies in the monitoring system. Participation is on a voluntary basis, and no incentives are being provided.

Community willingness to participate in this project is critical. CSPR assessed community willingness by holding community stakeholder consultation meetings. During these meetings CSPR explained the concept of budget execution and service delivery monitoring to the community, as well as its aims, expected outcome, and the process it entails. The community members were then asked if they were interested and, in the meetings, communities expressed great interest in this kind of project.

TRACKING TOOLS

At the community level, the tools that will mainly be used in budget tracking and service delivery are scorecards. CSPR has developed two types of scorecards:

- 1** The Budget Tracking Scorecard - This is a simple card aimed at comparing project inputs, physical outputs, budgets, and entitlements as recorded in financial accounts and audits, or as laid down in project and policy documents, with what is actually present in, or provided to, the community. This comparison gives a basic idea of the 'differences' that exist between official and actual statistics. Often the mere process of letting communities know their entitlements, or what the official budgets are for different projects in their area, is a significant element of empowerment, since most of the time common people, especially the poor, have no access to such information.
- 2** The Service Delivery Scorecard - This is the key output that is generated through community engagement. In simple terms it is a quick table that summarises the community's feedback regarding the performance of different services or projects. The community then scores these indicators in different focus groups, and then the reasons for the scores are shared using actual evidence or personal stories (as far as possible). The debate and discussion that surround the completion of the community scorecard become the basis for inviting suggestions from the community concerning what reforms can be made to improve the situation.



Below is an example of a Health community score card;

	Standard Performance Indicators	Score (1-5)	Reasons/Comments
1.	Positive Attitude of Staff		
1.1	Observance of working hours		
1.2	Polite behaviour		
2.	Management of the Health care Centre		
2.1	Cleanliness		
2.2	Existence of rules to guide operations		
3.	Quality of Health care Centre Services Offered		
3.1	Adequate medicines available		
3.2	Proper medical treatment of patients		
3.3	Availability of food for in-patients		
4.	Human resources		
4.1	Qualified staff		
4.2	Fair welfare conditions for staff		
4.2	Adequate number of Clinical officers		
4.3	Adequate number of Enrolled nurses		
4.4	Adequate number of Midwives		
4.5	Adequate number of Environmental Health Technicians		
4.6	Adequate number of Lab technicians		
4.7	Adequate number of Pharmacists		
5.	Patient care		
5.1	Reception of patients		
5.2	Positive relationship between staff and patients		
6.	Infrastructure and equipment		
6.1	Availability of clean and safe water		
6.2	Availability of transport/ ambulance		
6.3	Adequate number of staff houses		
6.4	Adequate toilets, kitchen, and shelter		
6.5	Availability of beds and bedding		
6.6	Communication facilities		
6.7	Availability of Maternity Unit		
6.8	Availability of a Laboratory		
6.9	Availability of Examination room		
7.	Equal access to the health care services for all members of the community		
7.1	No discrimination in providing medicines to patients		
7.2	No preferential treatment		
7.3	Maintaining a first come, first serve policy		

1 = Very Bad situation
2 = Bad Situation
3 = Average Situation
4 = Good Situation
5 = Ideal Situation

On this scorecard, indicators for Human Resources for Health are included to monitor the front line health care staff. For example, what is monitored is the number of clinical staff, midwives, pharmacists, enrolled nurses, and technicians, while in the field where service delivery is being monitored, communities decide whether or not there is adequate staff. This is done by checking the number of clinical staff available on record. People observe service provision and look at how long the waiting queue is at a particular clinic, and how long a patient must wait to be treated, for example.

Staff welfare conditions are also monitored. Furthermore, the community monitors the attitude of staff towards patients. Do they follow a first come, first serve policy? Is there preferential treatment or discrimination when providing medicines to the patients?

Findings from the scorecards in each community are shared with the rest of the community. To enable effective sharing of findings from the scorecards, a community meeting in each community will be held quarterly to discuss results from scorecards with community members. During these meetings, the findings of the monitoring work will be reported back through creative traditional communication channels, such as drama. Once the information is shared, community members can collectively reflect on the information gathered and decide what corrective actions it must take. The meetings might also help CSO's to develop a common understanding of key findings and define priorities for the communities. The community meetings also enable the communities to measure the progressive realisation of the government's commitments, and to measure the improvements in service delivery due to changes in the allocations and spending.

The government will be made aware of community opinions through the Budget Execution and Service Delivery Barometer, which was developed by CSPR as an alternative tool to measure government's commitment and performance in Budget Execution and Service Delivery, especially seen from the perspective of the citizens (the community). The barometer will be published at regular intervals. Apart from the barometer, communities conduct feedback meetings with the government authorities in a particular area to inform them of the results of community monitoring.

CONCLUSION

One of the initial results of this project is to have an informed and effective budget performance and service delivery monitoring system in place, that takes into consideration the views of the intended beneficiaries as well as their contribution, through a participatory monitoring process developed jointly with them.

The desired outcome of the project is that the targeted beneficiaries will begin to enjoy and have complete access to basic care services as a result of a positive shift in political will, budget execution, and service delivery management, resulting from sustained advocacy at all levels. It is anticipated that the participation of CSO's, and more specifically of the citizenry, will challenge government to invest sufficient resources to address the social concerns expressed by the citizens.

Finally, we anticipate the challenge posed to the government of accepting the results of service delivery monitoring exercises, especially when these results are negative.

CSPR has developed a tool and a network that enable the community to participate in the monitoring of health care funds and the quality of care provision, and to have a say in the discussions surrounding health care at a local level.

- In your country, is the community a respected stakeholder in the monitoring of, and reflection on, health care spending and quality of care provision?
- Can you mention (at least two) examples of successful participation of the community in policy making, planning, and monitoring of the health care system performance in your country? In these cases, have tools been developed to facilitate community involvement?
- How can the community be supported in your country to strengthen its voice and participation in discussions with policy makers and planners?

Casestudy **National Catholic Health Services (NCHS)**

Empowering Local Managers to Plan and Manage Healthwork in Ghana

George Adjei

NCHS



INTRODUCTION

The National Catholic Health Service (NCHS) is the largest member organisation of the Christian Health Association of Ghana (CHAG), an agency of the Ministry of Health (MoH). The MoH regulates and supports CHAG with resources, including staff from time to time.

The Ghana Health Service Act, 1996 (Act 525) separated service delivery from policy formulation, monitoring, and evaluation. Thus, the Ghana Health Service thereafter became the service delivery organisation of governmental health services. The teaching hospitals, the regulatory bodies and CHAG were transformed into agencies of the MoH by this law.

Previously, staff used to be allocated from the Ministry of Health to the faith-based sector by “secondment”, an arrangement through which the staff were employed by the Ministry of Health but were assigned duties in CHAG institutions. In recent times, the Ghana Health Service voiced its concern that such staff on “secondment” should revert to their system, because they were not using their services and this increased their manpower budgets. The reality is that most of these “seconded” staff did not fully identify with the institutions where they were offering services. As a result, in some cases there were constant threats of reverting to the Ministry of Health/ Ghana Health Service. Some actually reverted, in some cases for reasons related to the church’s principles concerning service delivery. These staff members were readily received by the then MoH or the Ghana Health Service, no matter the consequences of their sudden departure from the service delivery institution. The health sector in Ghana has never paid attention to human resource planning at the hospital level. The practice has been to assign newly trained staff or transfer these to health services. There is a staffing norm which prescribes the number of staff, for example doctors or nurses, for a given facility based on its level, namely the Regional or District Hospital and Clinic/ Health Centre. Tertiary institutions enjoy the autonomy to decide their own staffing norms. Thus, local managers are not involved in the decision on how much staff of each cadre are required to provide services. At present, this is still the case.

OBJECTIVES OF THE HR PLANNING PROCESS

The NCHS, in accordance with its Strategic Plan (2008-2013), is going to assist hospitals to develop HR Strategic Plans. These plans aim at improving the availability and productivity of the workforce in order to respond effectively to patient needs at each facility. The NCHS has been working in these two main areas since 2005.

In the actual context, availability means that the required skills

mix and numbers are present to meet the disease and health problems present at each institution. This therefore is context-specific and moves away from the generic staffing of hospitals based on norms and on the level of the facility, as is the case with the governmental health services.

The main objective of the planning process is to empower local managers to determine on their own, and at any point in time, what the staffing needs should be, based on the workload and following the WHO’s Workload Indicators of Staffing Need (WISN) approach. Another goal is to empower local managers so that they can plan the presence of staff or otherwise, well ahead of time to avoid excesses or shortages in specific health care worker groups. This helps managers in the development of a workable HR Plan for their respective institutions that can be understood and applied.

PROCESS

The Department of Health head office of the NCHS requested information from its thirty two hospitals on staffing over the last three years in order to assess the workforce situation in its hospitals. In addition to the HR data, workload statistics over the same period were also requested.

The NCHS head office is responsible for providing leadership, guidance, and capacity building in Human Resources for Health, HRH. NCHS organised seminars for hospital managers as a capacity building exercise in planning for HRH. The sessions were modelled on the “Writeshop” approach, where participants are “camped” with relevant data and guided to write their own plans. All the HR managers, and in some cases administrators, were invited to participate in planning exercises consisting of two separate five-day seminars. The programme was facilitated by five HR practitioners, including one in the first seminar from our sister network, the Uganda Catholic Medical Bureau. This process was quite new even to the facilitators, so there was a pre-session meeting of the facilitators to agree on the process and assign roles.

Most of the writing was done during the first seminar when participants received a Power Point presentation on specific aspects of the plan, e.g. what is involved in developing the Situation Analysis Section. The participants had to begin writing immediately using their data, and the facilitators supported them in this exercise. This was repeated for every section of the Plan. At the end of the first seminar, the process produced thirty Draft HR Plans for thirty hospitals.

The process included a situation analysis which took participants through the types and number of staff at the posts. This revealed interesting information to participants about their respective workforce. This stage highlighted important trends, such as the ageing profile, the cadres with high attrition rates, cadres craving further training, areas of high staff costs, costs

of training, effects of training on the workforce, technical versus support staff mix and proportions, etc. This provided input for the strategies, and at this stage it constituted an extremely important learning process for participants because they had never given consideration to these issues.

The second seminar concerned making assumptions about the workforce into the future and followed the same structure, namely a lecture and a writing session. The value of doing this was that participants obtained ample information about their respective staff, and that specific institutional knowledge about the workforce was used to analyse the situation, which was an important output.

We consider that a difficult aspect of the seminar for the participants was forecasting staffing needs. Staffing requirements were computed based on workload calculations². The result was related to the workload to determine both the types of skills and the numbers of a particular cadre required. This revealed shortages and areas of overstaffing of specific staff in service delivery.

Using the outcome of the Strengths-Weaknesses-Opportunities-Threats (SWOT) analysis of the workforce, participants themselves identified the solutions. These included the need to plan replacement of certain cadres nearing compulsory retirement, cadres where employment should be frozen, cadres that should be trained, the need to plan training in line with the development needs of the facility, and succession planning.

The second seminar was used to “fine tune” the Draft HR Strategic Plans and to assist participants in developing action plans with commensurate budgets for their implementation the next three years.

This approach to developing the HR Plans was adopted because there were few alternatives. The readily available option would have been to hire external consultants to do the same work. For a few consultants to develop thirty plans would have taken an enormous amount of time. Apart from this, the process would have lacked ownership by the hospital managers; “it would have been just one of the products of some external consultants who want us to implement something,” as one participant put it. Again, the quality and uniformity of the content would not have been guaranteed.

ACHIEVEMENTS

A key achievement is the ability of the HR managers and administrators to understand and use workload calculations to determine staffing needs. But far beyond this is the fact that they have been empowered to take local decisions about types and numbers of staff, and of when to employ them. Similarly,

managers understand which cadres should be reduced in numbers, and how. Another important fact is that managers are now able to undertake an audit of their workforce at any time, and to use the information gathered to take local decisions.

The process also provides evidence for certain human resource interventions. A participant remarked that “...training or future staff development must be based on anticipated needs from this analysis and no more training for training’s sake...this is good”.

Another achievement is the very well written HR Plans for the thirty hospitals within our network in a matter of weeks. The Strategic Plans include clear implementation activities, timelines, budgets, and persons responsible. This actually empowers local managers because they can take the management of their workforce seriously.

The Ministry of Health distributes the newly trained workforce among its agencies. In the case of the NCHS, this is done through CHAG. The staffing needs information will be relevant to CHAG when it seeks relevant staff in the distribution process that takes place on the Ministry of Health level.

So far, two hospitals have acted to address issues that stem from their Plans. St. Martin’s Hospital, Agomanya, observed from the situation analysis that about 90% of midwives are three years away from retirement. Immediately, some trainees have been identified and sponsored for midwifery training. In the case of St. Anthony’s Hospital, Dzodze, it has been observed that there are more than enough support staff, which has implied high staff costs and stressed technical staff because these cadres are fewer. Management is taking steps to reduce the support staff numbers, including the possibility of transfers to sister institutions. This hospital has also drafted a plan to actively recruit midwives, because 7 of them will retire in the next three years.

CHALLENGES & LEARNING

One concern was the reliability of the HR data brought to the first session by some institutions. The second session offered participants the opportunity to correct it.

The sessions were stressful for all, participants and facilitators alike. There was little time, especially for the calculations, so some participants had to work late into the night to keep pace with their colleagues.

HRH governance can be improved when local managers are also required to participate. In Ghana, the strategic planning and management process of the health care workforce over the years has not actively involved local managers, but only personnel managers. The reality is that local managers have the

² The workloads were estimated using rates of “staff:number of patients seen” in hospitals that perform adequately, and these were then used as benchmarks.

capacity and commitment to make local resources, in terms of time and money, available for HRH because it helps them keep an eye on the workforce from the corporate, local level.

Another learning element is that the seminars for human resources plan writing could be a powerful tool for drafting plans and budgets in a relatively short time, given it's managed properly, compared to hiring consultants to perform the same task. Part of the process allowed the managers to share their plans for peer review while in development, which allowed valuable feedback and further improved the plans.

RECOMMENDATIONS

The process of the HR Strategic Plan development could be improved, and organisers should keep in mind that local managers are adult learners and that it is therefore important to provide ample time for understanding the material, writing, and the like.

Effective, local HRH strategic management that ensures availability and productivity can only be realised if the process involves ample stakeholder participation and consultation (local community, health care professionals, managers, trade unions, and training institutions, among others). This stakeholder engagement must also be continuous and sustainable for as long as there is need to manage HRH.

NCHS was able to realise the empowerment of health managers by providing them with a tool to develop HRH plans based on the needs of their health institutions, and by teaching them how to use this tool.

- In your country, are tools and guidelines available and followed to assist local HRH managers to understand their HRH needs and to make the relevant planning?
- Does a (built-in) mechanism exist in your country/ organisation to allow for reflection in order to gain a better understanding of the effectiveness of HRH management?
- How can you introduce tools and guidelines, or make better use of existing ones, for HRH policy making and planning in your country/ organisation?

Casestudy

Regional Network on Equity in Health in East and Southern Africa (EQUINET)

Lobbying at regional level. Institutional Collaboration on health workforce issues
Yoswa Dambisaya

Yoswa Dambisaya





INTRODUCTION

The Regional Network on Equity in Health in East and Southern Africa (EQUINET) is a network of professionals, civil society members, policy makers, state officials, and others within the region who have come together as an equity catalyst, to promote and realise shared values of equity and social justice in health care. EQUINET has a focus on strengthening national health systems that are publicly funded, comprehensive, and centred on people. Such health systems should offer equitable and universal access to health care.

The East, Central and Southern African Health Community (ECSA HC), previously known as the Commonwealth Regional Health Secretariat for East, Central and Southern Africa, is a regional inter-governmental organisation that provides member countries with a unique framework for addressing health care problems that require joint action. As an inter governmental organisation, ECSA HC enjoys direct links with regional health policy makers, including Health Ministers and Permanent/ Principal Secretaries, as well as an extensive network of regional health care institutions. ECSA HC also maintains strong linkages with international development agencies based in the region and other parts of the world. Through these mechanisms, ECSA HC contributes to improve health in the region by undertaking activities that aim at promoting and encouraging efficiency and relevance in the provision of health care services in the region.

Both EQUINET and ECSA HC are active in the East and Southern African (ESA) region, and both have identified Human Resources for Health, HRH, as a priority issue. Most ESA countries have severe shortages of health care workers, and all of them have a deficient distribution of existing ones. Typically, there are more health workers in urban, rich areas than in rural, poor ones. Most countries face the challenge of retaining their health workers in the public sector facilities.

RESPONSES TO THE HRH CRISIS BY EQUINET AND ECSA HC

The strength of EQUINET lies mainly in research, networking, and advocacy, while ECSA HC has high level policy forums and access to policy makers. Whereas EQUINET is able to generate evidence, such evidence may not necessarily reach the decision makers.

Thanks to the ECSA HC processes, HRH problems have been addressed at the highest level (Health Ministers Conference, HMC), with specific resolutions for action at meetings in 2003, 2004, 2005, 2006, 2007, 2008 and 2009. At the 44th HMC

(2007), for instance, the Ministers resolved to:

- adopt a common position on how to compensate for health workers recruited by developed countries;
- adopt a common position on ethical recruitment of health workers; and
- develop financial and non-financial strategies to encourage retention of health professionals.

EQUINET, for its part, undertook understanding the dynamics of the patterns of professional migration of health workers within and across country borders in ESA, and the factors responsible for such patterns. An emphasis on the early HRH work within the network was on factors that encourage health workers to stay. Preliminary work in Namibia and South Africa pointed to the critical role that non-financial incentives play in retention.

The EQUINET research and dialogue identified three areas of focus for action with health workers:

- Valuing health care workers so that they are retained within national health systems. This includes reviewing and implementing policies on non-financial incentives for HRH, such as career paths, housing, working conditions, management systems, and communication.
- Promoting relevant production of HRH, particularly in terms of the health personnel for the district and primary care levels, and drawing on experience in the region regarding the training of auxiliaries.
- Responding to migration, which requires completing the missing evidence with respect to migration (levels, flows, and causes), financial flows, costs (the benefits and losses), return intentions, and the effectiveness of current policies.

These messages needed an audience, such as the one provided by the ECSA HC high level forums.

To maximise the comparative advantages of both organisations, EQUINET and ECSA HC signed a Memorandum of Understanding to collaborate on health workforce issues: the EQUINET-ECSA HRH Programme of Work on Health Worker Retention and Migration.

Through this programme, work has been carried out in five countries – Kenya, Swaziland, Tanzania, Uganda, and Zimbabwe – that includes applying non-financial incentives to retain health workers. In addition, regional reviews were undertaken on how non-financial incentives are used in 16 ESA countries, and on the impact of codes of practice on health worker migration. A country study (Kenya) complemented a review regarding the analysis and assessment of impacts of health worker migration. Both studies exposed the inadequacies of the available analytical tools.

PARTNER ENGAGEMENT

Joint meetings were held between the organisations to agree on common methodologies before the studies commenced, to ensure that ECSA HC priorities are reflected in the HRH work programme, and to share experiences and emerging findings.

EQUINET has been represented at all ECSA HC forums – the Directors Joint Consultative Committee (DJCC) meetings and Health Ministers Conference ; while ECSA HC has been equally active at EQUINET meetings. The results from the studies have been presented at ECSA policy forums, and the recommendations and resolutions that emerge from such meetings reflect a language that is pro-equity.



When ECSA HC was in the process of developing its HRH Strategy for 2008-2012, EQUINET was an active participant throughout the process. The commitment to the collaboration is reflected in the Strategic Objective on HRH retention and migration.

ECSA HC participated in the EQUINET HRH Meeting (Feb 2009) which called for:

- Strengthening institutional capacities for improved governance, and delegating more power and authority to, and strengthening the capacity of, the district level of health care systems;
- Establishing or improving performance management systems with clear-cut rules of performance and independent evaluations; and
- Governments to take leadership in the provision, supervision, and support of Community Health Workers (CHW's) within HRH strategies.

The above positions were informed by the realisation that weak institutional mechanisms, such as weak district management structures that had a lot of responsibilities but not the necessary power and authority, were part of the problem. The call was for establishing and improving performance management

systems, recognising that some effort was already undertaken in some countries of the region (such as Rwanda), but that even there more could be done. Performance management systems must still be established in most of the countries in the ESA region.

In March 2009 these resolutions were discussed during the HRH session at the 48th HMC, re-emphasising the need to find evidence-based solutions in order to face the HRH crisis in the region. The agenda for the next phase of the HRH work programme was therefore increasingly set towards the existing demands for evidence. The partnership enjoys the enviable position of conducting demand-driven research in countries, under the mandate of ECSA HC and fulfilling HMC resolutions.

The 48th Health Ministers Conference re-affirmed its endorsement of the EQUINET-ECSA HC collaboration in Resolution ECSA/HMC48/R2, which, inter alia, directed the Secretariat to:

Continue the collaborative work with EQUINET, including consolidation, repackaging, and dissemination of findings from the ECSA-EQUINET programme on HRH and particularly on incentives for HRH retention, to inform policy, guidelines and programmes.

ECSA HC was represented at the highest level (by the Director General) at the EQUINET Regional Conference in September, 2009. That effort was returned at the 50th HMC, where the EQUINET delegation included the Director who gave a keynote address emphasising the need to keep an eye on equity.

The 50th Health Ministers Conference subsequently called for monitoring inequalities in health care. That HMC adopted explicit language for equity in health care, stating:

The 50th ECSA Health Ministers Conference, noting that it will be difficult and in some cases not possible to achieve the Millennium Development Goals without reducing health inequalities, urged Member States to report evidence on health equity and progress in addressing inequalities in health and directed the Secretariat to strengthen capacities and measures to monitor and report on progress in addressing inequalities in health.

This provides more opportunities for the two organisations to work together towards a common agenda.

FUTURE PROSPECTS FOR THE EQUINET- ECSA COLLABORATION

The two organisations are committed to the collaboration, and the MoU has been extended for another five years (2009-2014). The future directions include:

- Work on migration: with emphasis on how countries in the ESA region have responded to HRH migration; what the costs, impacts, and benefits of health care worker migration have been in the region; and how the region may benefit from initiatives such as the World Health Organization Global Code of Practice on the International Recruitment of Health Personnel.
- Continued engagement in policy forums: presentation of evidence and contribution to recommendations and resolutions – EQUINET is currently part of the ECSA HC Monitoring & Evaluation group set up in July, 2010 to keep track of the implementation of ministerial resolutions. The Monitoring & Evaluation Group has developed indicators that have been accepted by countries; hence, it will be possible to observe what influence the resolutions are having at a country level.
- Follow up country work, based on ECSA-generated plans and country demands.
- Assessment of the impacts of prior work, using the indicators alluded to above.
- Emerging issues: Impact of Global Health Initiatives, Codes of practice, bilateral agreements, “brain circulation” – all these are areas that present opportunities for further work between EQUINET and ECSA HC.

SOME OF THE STEPS TAKEN:

- In July 2009, a consultation took place to draw up a proposal for work on assessing the impacts of health worker migration in the region. This also included participants from WHO-AFRO and the South African DC as well. The agreement was to conduct studies in at least 8 countries, 6 in the region and probably 2 in West Africa.
- In May 2010, that idea was taken further in a broader consultation that included Wemos from the Netherlands. Again, the idea of a multi country study was endorsed and efforts are underway to secure funding.

CONCLUSION

Through this partnership, both EQUINET and ECSA HC have benefitted from each other’s strengths and comparative advantage. Work carried out by EQUINET has informed some of the policy positions taken by ministers of health in the region, while ECSA HC has been able to generate demand-driven evidence in pursuit of ministerial directives. The profile of EQUINET within the region has grown on account of the formal partnership with ECSA HC. At the same time, ECSA HC’s profile as a learning organisation has been enhanced through the partnership. This has been a win-win situation for both partners.

A number of challenges lie ahead, such as quantifying the effect of the various initiatives undertaken by the collaboration, but the recent development of Monitoring & Evaluation indicators should facilitate this process. Above all, the two organisations remain committed to the collaboration.

EQUINET gives an example of a successful institutionalized collaboration between health policy makers and researchers at regional level

- What opportunities do you see in your region or country to develop a cooperation between the policy makers (Ministry of Health, Health Service Board, Civil Service Commission, Ministry of Higher Education, Ministry of Finance and others) and the research institutions (universities, etc) to address Human Resource for Health issues ?
- What steps have to be taken to realize this cooperation?
- What should be priority areas to address by this partnership in your country?



Participants at the May 2010 Meeting

Casestudy

Southern African Network of Nurses and Midwives (SANNAM)

The Role of Professional Organisations Organisations and Networks to Address the
Human Resources for Health Situations: Advocating for nursing directorates in the
SADC region

Philemon Ngomu





BACKGROUND

SANNAM is a regional organisation formed in 2000, at the International AIDS Conference, in Durban, South Africa. The nurse leaders from the Southern African Development Community

(SADC) held a pre-conference meeting to identify and agree upon an area of focus to enhance the status of nursing in the region. This resulted in the creation of SANNAM, as a network with a common vision, focusing on the development of strategies to combat HIV and AIDS, and giving a genuine collective regional response.

This unique governance structure has grown and extended its scope to address other critical health challenges in the region, and currently plays a pivotal role in enhancing collaboration and coordination of several activities in the 15 SADC states. SANNAM provides platform for Nurses in the region meet to address issues of common interest in health, nursing and social welfare of nurses and the general populations in the region, and to address challenges caused by the impact of HIV/AIDS on the working conditions of Nurses and Midwives and other Health Care Workers, and the challenges on human resources for health.

A major objective of the SANNAM 2009 – 2012 Strategic Plan is to identify priority areas of focus for National Nurses Organisations to effectively contribute to Health Systems Strengthening by innovative ways for lobbying and advocating for improved Human Resources for Health (HRH) and working conditions of nurses and midwives in the region. To this end, it was agreed to advocate and lobby for the establishment and/or strengthening of Directorates of Nursing within the countries to improve the governance and profile of nursing in the region.

THE CAMPAIGN

The intent of the campaign for the establishment of a Directorate of Nursing Services in each of the SADC countries arose from the realization that whereas nurses are the majority health care professionals in the region, their affairs are not handled at high level within most of the government structures. Consequently, nursing issues do not receive the recognition deserving of a major stakeholder in health services delivery; indeed it was the view of nurse leaders in the region that often only lip service is paid to nursing concerns.

The common experience regarding the way nursing issues are handled by governments at the country level was that of obstacles to any nursing initiatives and of nursing affairs often

managed under medical directorates, with no nursing voice at the decision making level. In effect, in most SADC countries, the topmost nursing manager/leader is only an implementer of decisions taken by others.

SANNAM therefore undertook this “revealing” and “learning” process that allowed exploration of governance challenges faced by the nursing community. Though fronted as a campaign for nursing directorates, the initiative has been as an entry point for raising nursing issues within the countries in the SADC region. At the time of this report, the process is ongoing, and other strategies are being explored to address obstacles such as the socio-political and economic diversities among the countries making standardization and political commitment difficult at the regional level. An early challenge was the fact there are remarkable differences in the structure of Ministries of Health, and different approaches to the HRH crisis from country to country.

OBJECTIVES AND PROCESS

The main objective of the campaign was to call for the establishment of a “Directorate of Nursing Services”, or a structure at a similarly high level, that would be capable of defining policy and making decisions and therefore be directly accountable to the Director General/Permanent Secretary/Principal Secretary on all issues of nursing, as the case may be, in the respective member countries.

The process followed so far has included:

- A meeting of Nurse Leaders from: Lesotho, Botswana, D.R Congo, Zimbabwe, Namibia, Malawi, Mozambique, Seychelles, Madagascar, Tanzania, Zambia, South Africa, Mauritius, and Swaziland in September 2009, which recommended national level consultations with the highest existing nursing representation within the Ministry of Health to determine the scope and responsibility of existing structures and identify gaps in the lobby and advocating role of the nursing unit or representative and brief the secretariat;
- Report back by national nurses organisations/associations (NNAs) on the country situations at the February 2010 Network meeting;
- Development of a database on public health indicators, HRH coverage and functions allocated to existing nursing structures within the ministries – this is undertaken by Botswana Nurses Association working with the SANNAM secretariat (not finalized);
- The secretariat then lobbied the SADC Secretariat health-sector unit to transmit our concern to the summit of health ministers;

- On the occasion of the “2010 International year of the nurse” and the 2010 Nurses day celebrated on 12 May, briefing notes were released emphasizing the issue and sent to Ministries of Health via member NNAs; and other regional organisations for communication and support;
- NNAs were further instructed to continuously update the network by reporting to the secretariat, and share with other members in the December 2010 network meeting.

DESCRIPTION OF MAIN ACTIVITIES AND OUTCOMES

Nursing leaders who attended the September meeting went back home and shared information by interacting with health officials (decision makers), policy makers and other professionals organisations or unions on the existing structures, how relevant they are to advocate for nursing/HCWs issues and how nursing is especially positioned to effectively influence health policies in the country. This was at the discretion of the leader; using any methodology, instrument or approach he/she felt appropriate to collect the necessary information that may assist to analyze the situation at country level and compare with other countries, and to provide a feedback to secretariat.

The results revealed the diversity in structures, already alluded to, with even different terminologies used to describe similar functionaries, for instance Nursing Officer, Chief Nursing Officer, Commissioner of Nursing Services or Director of Nursing Services. Furthermore, the core functions and reporting mechanisms were very different depending on country situation, political history and stability, public health priorities, good governance, social status of populations and many other factors impacting on the quality of the health systems in the country.

Some countries such as South Africa, DR Congo and Madagascar did not have a Chief Nursing Officer or Director of Nursing to directly address nursing issues. In many cases where such units exist, they had no authorities to influence decisions or reported to the general medical directorate which, often gave no priority to the concerns of the nursing profession, there were no specific functions allocated to the unit that had direct influence on the decision making process.

Furthermore, not much was happening as response to our call after the consultations. Only Zimbabwe instantly positively responded acknowledging the need to have such a directorate to focus on rebuilding the nursing workforce after the political instability. The position of Director, Nursing Services already existed, was given more authority to reorganize nurses and work more closely with the Director of Health Services to develop a

national emergency response to the HRH crisis. In a few countries such as Botswana, Lesotho, Mauritius, Seychelles and Swaziland the structures existed at a Chief nursing office or a Directorate of nursing, NNA leaders expressed a level of satisfaction or good collaboration with the unit in advocating for nurses issues such as wages and conditions of employment.

Some NNAs such as Malawi and Zambia were still coming from a transformation process to become unions and were still at too early a stage to effectively collaborate with government units as it is not a given opportunity for any government to accept unionization. Some other NNAs such as Angola, Mozambique, and Namibia were more static and did not actively report on their lobbying and advocacy role; while other such as DRC were challenged by emerging from war and a need for a new orientation. Tanzania was reportedly working, first, to improve the image of nurses in the country.

The challenge at hand was illustrated by the feedback from South Africa, which though the most advanced country in the network does not have this unit as yet. Mr E. Mafalo, then president of DENOSA and Chairperson of SANNAM shared his frustration at being taken around in circles, saying:

“...we do not accept the argument, which the National Department of Health is advancing, that the advancement of nurses to prominent positions within the Department of Health must start with the provinces first, before appointments can be done by the national office. As a delaying tactic we are told that we must also formally submit the job description and the key performance area ourselves. We have a legitimate structure in the Department of Public Service and Administration that is dealing with work-study and they are capacitated to determine the job description and the key performance areas for this position. ...Our responsibility is to forcefully drive the process, as agents of change. No one other than nurses themselves can make the change happen. But it will not be without hurdles to jump over”.

Those are some of the realities reported on this initiative so far, more challenges than we expected, less success than we expected by now. However, at the December 2010 meeting of SANNAM, Zambia reported on an innovative approach that may be more effective to enhance nurses lobby and advocacy capacity, while being acceptable and engaging than a Directorate of Nursing. That is a TRIAD model that brings together a National Network of Nurses Unions and/ or Associations, Regulatory Board and a representative in the Ministry of Health. Any situation pertaining to the profession will be brought back to this platform, discussed and deliberated upon, and the position to be presented at the decision making table is consultative and represents the nursing workforce in general. SANNAM is

persuaded to adopt this approach as a regional strategy, but more needs to be done to further discuss application strategies at regional level. The question may, however, remain about what level of nursing representation will join the TRIAD arrangement from the government side.

A particular concern was the fact that most of the Ministries and the SADC Secretariat Health sector Unit did not officially respond to our call for consultation on the issue. But we are gratified by positive developments such as the creation of the position in some countries such as Seychelles and Lesotho, and the promotion of some nurse leaders to head the unit or deputized the appointed person. In other countries such as Swaziland and Zimbabwe, the unit has been upgraded. The long-time impact of these measures has to be assessed, and SANNAM will keep track of further developments.

CONCLUSION

In conclusion, we believed that, if nurses are in the majority in the Department of Health, then they must be given a position with commensurate power to the numbers nurses command in relation to other health workers, so that they can influence decisions in the health care system in their countries. Using the regional profile of SANNAM, we hoped to influence SADC countries to establish high profile nursing directorates to manage nursing affairs at a high level within the ministries of health. We learned and are persuaded that Regional Networks of professional organisations are the most effective driving forces to influence policies and good governance for the improvement of HRH in our region. Together in a powerful structure such as SANNAM we can do better than when we stand alone in countries. Within this platform, with the continuing support from our regional and international partners, we are committed to the promotion of the caring profession.

SANNAM, as a regional organisation, paid attention to the fact that the voice of nurses in national policy making is not heard sufficiently because of the absence of this profession in key directorates at the Ministry of Health.

- How are nurses organized in your country to enable them to be a respected stakeholder in policy making and planning for health?
- Do in your country nurses have a senior position within the HRH directorate/ department of the Ministry of Health?
- How can the voice of nurses regarding their own tasks, and rights been strengthened in your country?

Casestudy **Wemos**

Lobby for the Global Code of Practice on the International Recruitment
of Health Personnel

Remco v.d. Pas





THE SOCIOECONOMIC AND POLITICAL CONTEXT

At the international level, there is a growing recognition of the problems caused by the shortages of health personnel in developing countries. There is also a growing recognition by international actors that they need to contribute to solutions. The European Union has prepared a Programme for Action to tackle the critical shortage of health workers in developing countries. At the World Health Organization, a Global Code of practice has been in development since it was recommended as part of the Kampala 2008 agenda for action.

Around 23% of the doctors trained in sub-Saharan Africa are currently working in OECD countries. Most OECD countries lack policies that would enable the health system to be fully reliable on their domestic health workforce. In Europe, the United Kingdom is especially known for recruiting foreign health workers, mostly from outside the European Union. In the US, 1 out of 4 doctors is foreign-born. In the Netherlands, where up until now there are few foreign-born doctors, there are recent cases of health personnel being recruited from low-middle income countries with a shortage of health workers (from India in this case), and this is expected to increase, as the demand for health services is increasing and the number of domestic health workers declining.

Wemos works from a vision that every person has a right to health. Wemos wants OECD countries to acknowledge their responsibility to:

- (1) stop recruiting health care workers from developing countries because this undermines health care systems in these countries; and
- (2) contribute to the improvement of health care workers' working conditions and health care systems in low income countries, so that these health care workers have more reasons to stay there. The Global Code of Practice on the International Recruitment of Health Personnel that was endorsed at the World Health Assembly in May, 2010 is, although not legally binding, a powerful instrument to hold countries to these responsibilities.

ACTIVITIES

The objective of our lobby is to have a fair and solid Code of Practice on the International Recruitment of Health Personnel. Several strategies and activities have been followed and implemented to reach this objective. In the Netherlands we developed and established a network with Dutch organisations: the

Dutch HRH Alliance. The objective of this alliance goes beyond that of the Global Code. Its aim is to advise on policy options to stop the Netherlands from the "unethical recruitment of health care personnel" and to use Dutch labour market expertise to build capacity on strategic planning and HRH management in other countries. For international lobbying, in this case regarding the Global Code, it is useful to have a national alliance that supports Wemos' positions vis-à-vis our delegation at the WHO meetings. In the last two years this alliance, consisting of NGO's, labour unions, academic institutions, and medical professional organisations, among others, organised dialogue and multi-stakeholder meetings with the Netherlands government on the development and international recruitment of the health care workforce.

Wemos is a member of Medicus Mundi International (MMI), is on the steering committee of the Health Workforce Advocacy Initiative (HWAI), and maintains close relationships with other NGO's and networks working on Human Resources for Health, such as Realizing Rights and the People's Health Movement (PHM). We feed each other's positions and organise events together, with the purpose of coming to a coherent and strong international advocacy on global health care policies for health care systems and human resources for health.

One component of this lobby took place on the WHO EURO level: on behalf of Medicus Mundi International, Wemos gave input into and read a civil society statement on the content of the Global Code at the WHO EURO meeting in Copenhagen in September, 2009. The same was done during the WHO Executive Board meeting in Geneva in January, 2010.

The main lobby was conducted before and during the World Health Assembly (WHA) in May, 2010. Wemos was the main civil society representative during the inter-regional stakeholder meeting on the code with UN and member states' representatives that preceded the WHA.

During the WHA, Wemos/ Medicus Mundi International and others organised a side event, wrote letters to the Dutch delegation, and kept in touch with delegations of 'like-minded countries' before and during the final negotiations on the code.

In the Netherlands and abroad Wemos, Medicus Mundi International and the alliance got attention in the media on the topic of health care workforce migration. This was done by writing articles for magazines and newspapers.

Overall, the lobby activities were implemented as planned. We kept our agenda flexible to be able to participate in relevant meetings and events upon invitation. Wemos maintained

dialogue and communicated actively with crucial stakeholders, both governmental and non-governmental actors, in this debate.

Wemos was asked several times to provide technical input and advice on international health care workforce mobility by the Ministry of Health as well as the Ministry of Foreign Affairs in the Netherlands.

ACHIEVEMENTS AND CHALLENGES

Key achievements include that amendments were made to the text of the Code thanks to the lobby carried out by civil society organisations before and during the regional meetings and the WHA. These include: reference to the right to health care and ethics, and to the need for developed countries to invest more in their domestic health care workforce, as well as to their responsibility to mutually strengthen health care systems when recruiting health workers from abroad.

Another key achievement is the relationship that has been established with the Dutch delegation to the WHO: after initial reservations, the ministry representatives now recognise Wemos as an important player and expert in this area, and ask for our advice regarding this matter.

A key challenge is ensuring meaningful participation in civil society consultations organised by donors/ international organisations. Regularly, CSO's are invited for consultations for 'window-dressing'. A second challenge is the funding of these CSO's, as this is often dependent on the same donors and international organisations. This hinders CSO's from being (constructively) critical about the roles and responsibilities of every one of those organisations.

CONCLUSIONS AND LESSONS LEARNED

Entering into dialogue and delivering constructive inputs into policy proposals can influence matters. It has helped our case to acknowledge the efforts that the EU, the Netherlands, and the US are already undertaking to regulate workforce migration and develop their own health care workforce. It helped to build a good relationship and enter into a dialogue, because it eventually brought our position across.

In the Dutch context, Wemos, acknowledging the willingness of policymakers, is also in dialogue with health care workers and hospitals, which benefit from recruiting foreign workers. Initially telling them that under no circumstance should they

recruit from countries with a health care worker shortage makes it difficult to enter into a dialogue. Instead, we ask about their situation and other options they see in order to have a sufficient and skilled workforce working in their institutions. Placing ourselves in their position has helped to find common grounds and start looking for solutions that are acceptable to both parties.

The recommendations for agencies that would like to implement this activity include being constructive and avoiding blaming and shaming.

Another recommendation is to be prepared to – temporarily – set your own agenda aside for the sake of entering into a dialogue with others who may have other interests. In this sense positions like 'Agree to disagree' can help to build a coalition, as long as there are sufficient common grounds. For instance, Workers' Unions might have a different agenda than community organisations regarding health care. Finally, it is important to respect each other's views, recognise the power relations at play, as well as consider individual rights to health care workers and also the population's right to health care.

WEMOS describes that the (successful) lobby for sound migration regulation policies and regulations at a national level is a tough and long process, which includes a variety of stakeholders that have different interests.

- What kind of health lobby networks exist in your country?
- Are these lobby networks interested in including the issue of health care worker migration in their agendas?
- Does the lobby networking you participate in aim at listening to all stakeholders involved in health care worker migration before the lobby statement is brought to the policy makers?
- Within the lobby network, is there a culture of willingness to "give and take" when formulating policy?

DISCUSSION

DISCUSSION

Despite the efforts made at local, national, and global levels to improve the Human Resources for Health situation, HRH plans are usually implemented only partially or poorly, or do not respond to the needs of different groups of health care workers or communities. This is due to several reasons, including not only poor management but also poor governance. This booklet focuses on governance issues and presents several experiences of how civil society can influence decision making.

The way in which HRH policies are formulated and implemented can be influenced through several governance interventions:

- ensuring that different groups that have a stake in these policies participate in their formulation and implementation, as well as providing a level playing field for participation;
- having a committed leadership with the political will to change, which allows for coordination of the participating groups and allocating resources;
- having evidence about the current situation and about effective interventions that take place in different contexts; and
- setting up, implementing, and adhering to rules and regulations and accountability mechanisms.

The type of activity undertaken to improve governance depends on the power of the organisation to influence decisions, and its interest in doing so. The partners of Cordaid that present their case stories in this booklet, civil society organisations, professional associations, communities, NGO's, and Faith-Based Organisations (FBO's), are not in government and have to find ways to place their own interests on the agenda of the Ministries of Health, for example.

Professional organisations represent the interests of health care professionals; in many countries these associations represent nurses, midwives, and doctors, and they often work individually. The case stories show the need to work together at the regional or national level to influence government's decisions that affect their branch, as the NONM (National Organisation of Nurses and Midwives) in Malawi and SANNAM (Southern African Network of Nurses and Midwives) in Southern Africa cases illustrate. This can have a very positive impact in various ways. For example, NONM was able to convince the Ministry of Health to revert the decision to stop scholarships for nursing students through campaigns, and counted on the support of students, their families, and civil society organisations at both the national and international levels. At the same time, this success had to face the challenge of meeting the high expectations of students and their families, and of the lack of understanding among stakeholders regarding the reasons for why a professional organisation should become involved in policy decisions. Another example is SANNAM, which set up a campaign

to lobby for a Directorate for Nursing in the Ministries of Health in Southern Africa, thus aiming at establishing official structures for policy making that concerns nurses. A strong point was the regional collaboration that there was among national professional organisations, which reinforced the national activities. Although this campaign has not resulted (yet) in the establishment of such a directorate in each country, it has mobilised organisations in different countries to find ways to improve the position of nurses when decisions are made regarding HRH. Both examples show that the success of lobbying and campaigning by professional organisations requires the capacity to create willingness among other stakeholders to listen and collaborate, as well as to communicate clearly formulated messages that other stakeholders can understand and are willing to consider.

At the national and international level, *civil society networks* can influence policy making when they form coalitions to increase their own influence and power. This booklet provides two interesting examples. First, Wemos set up a national level network of Dutch organisations involved in HRH to advise on HRH policy options in the Netherlands, specifically concerning migration and the implementation of the WHO Code of Practice. Internationally, Wemos participates in different civil society alliances, and these networks organise various activities to influence global policy making. Through a consultative process amongst members, such networks define common positions that are communicated in various ways. Examples include organising side events during large international conferences and meetings, such as the World Health Assembly, as well as submitting letters to international organisations that are signed jointly and clarify a common position (e.g. on migration). Another interesting method is partnering between networks, as shown in this booklet. A regional network of civil society organisations, researchers, professionals, and policy makers that focuses on research, advocacy and networking, EQUINET (Regional Network on Equity in Health in East and Southern Africa), set up a partnership with an inter-governmental network in Africa (ECSA HC, the East, Central and Southern African Health Community) that enjoys easy access to policy makers. This was mutually beneficial because EQUINET provided the necessary evidence that ECSA HC could then use when lobbying to generate changes in policy making. This therefore strengthened the activities of both organisations. This was possible because of both networks' willingness to engage, illustrated by laying down their collaboration through a Memorandum of Understanding, a joint action plan, and by participating in each other's high level meetings.

Health service in rural areas is often provided by *Faith-Based Organisations* (FBO's), which are often the main service provider. These FBO's need to make sure that they are able to

participate in decision making regarding HRH, and that they are taken into account in planning and resource allocation processes. This can be done in several ways:

NCHS (National Catholic Health Service) in Ghana helped hospital managers there to plan their HRH more adequately by relying on information from their own management information systems, through joint HRH plan writing. This empowered the hospital managers and helped them to improve their planning based on actual figures. Using local data can also be beneficial during negotiations with other partners surrounding resources and activities. CSSC (Christian Social Services Commission) in Tanzania formalised its service provision by negotiating Service-Level Agreements. This type of “contract” defined the rights and obligations of both parties involved, and ensured that the Faith-Based Organisations were taken into consideration by the government when allocating resources.

Finally, at a local level, communities can increase their influence through social accountability mechanisms. *Civil society organisations* can help in this process by developing participatory monitoring and evaluation tools, as CSPR (Civil Society for Poverty Reduction) showed in Zambia. CSPR developed a community scorecard to allow monitoring and evaluation of health care facilities by communities; this scorecard must still be implemented. These tools are important if social accountability mechanisms are to be effective, but this is not enough. It is also essential that all stakeholders, including the government, accept that communities can hold providers accountable for their performance, and that the voice of the communities counts in decision making. This entails capacity building at the community level, and requires using and analysing the tools, as well as expressing points of view in meetings where different types of stakeholders are present.

These case stories illustrate various approaches that enable civil society to influence policy making and implementation. These are some examples, although many more examples need to be documented to allow for joint learning. At present, knowledge is lacking regarding how to establish partnerships and work within them, how to monitor and evaluate the performance of networks and measure results, how to ensure that social accountability mechanisms exist and function properly, and what the best approaches are to strengthen the capacities of civil society organisations in order to maximise their level of influence. The case stories also intend to initiate a debate among other civil society organisations concerning how they can increase their influence and promote their interests better when policies are formulated and implemented.

Cordaid’s strategy for the coming years is to promote a multi-stakeholder approach called Communities of Change (CoC) at

different levels: sub-regional, national, regional, and, whenever possible, global. This approach means that Cordaid promotes the establishment of CoC’s in which relevant stakeholders are interlinked and communicate to identify common grounds in order to find solutions to various problems, especially when complex policy and social issues are concerned. If the challenges mentioned above are to be successful, they must be addressed. This will make the CoC’s the vibrant and influential forums they are meant to be.

According to the World Health Report 2006, 57 countries face a critical shortage of health workers. This affects the quality of care provided to their inhabitants, as well as the progress made towards achieving the Millennium Development Goals. In response to the critical workforce shortages, many institutions at national and international levels have made efforts to address the shortage and performance of health workers. Among these actors are Cordaid and its partners, that identified the shortage of Human Resources for Health (HRH), especially in rural and underserved areas, as one core problem that stands in the way of delivering sufficient quality health services to the target populations.

The cases presented in this booklet represent the outcome of a Linking and Learning (L&L) trajectory initiated by Cordaid, concerning Governance in the field of Human Resources for Health. This L&L trajectory aimed at making it possible for nine non-state actors (Civil Society Organisations and Faith Based Organisations) to learn from each other's experiences in influencing HRH policy formulation and implementation. Each participating organisation wrote a case story about its relevant experiences, and all these case stories were exchanged and discussed. Seven case stories are presented here.

The seven case stories presented show the efforts made by Civil Society Organisations to address governance in Human Resources for Health. The case story of Wemos presents an effort to improve the implementation of the Global Code of Practice on The International Recruitment of Health Personnel through international lobbying. The National Catholic Health Service (NCHS) in Ghana aims to help hospitals develop HRH strategic plans by organising writeshops for local hospital managers, and the case story of the National Organisation of Nurses and Midwives (NONM) from Malawi presents an effort to influence national policy planning to keep the provision of

scholarships for student nurses. The collective of nurses and midwives (SANNAM) in South Africa strives for better HRH policies. They aim for improved working conditions for nurses and midwives in the region by lobbying for a Directorate for Nursing, so as to allow the inclusion of nurses' interests when HRH plans are formulated. These efforts, which aim at improving the efficiency and effectiveness of HRH policies, show us the importance of having various stakeholders influencing the policy making process to make sure that different interests are taken into consideration. The case story of the Civil Society for Poverty Reduction (CSPR) in Zambia presents an effort to improve accountability at a local level.

And, finally, two case stories focus on partnerships that aim at having a level playing field, where groups that have different interests and play different roles are able to participate. The Christian Social Services Commission (CSSC) in Tanzania describes a Service Agreement between local government authorities and health facilities, whose purpose is to enhance the provision of quality social services in rural areas. Lastly, the EQUINET (Regional Network on Equity in Health in East and Southern Africa) and ECSA HC (East, Central and Southern African Health Community) case illustrates an interesting effort where two organisations work together to complement each other at the regional level: EQUINET provides the necessary evidence that ECSA HC then uses for lobbying and advocacy in the field of Human Resource for Health.

CSOs have a role in policy influencing. In the case of good existing public policies, CSOs have a role in ensuring stakeholder participation, and holding the government accountable for correct implementation of their policies. Communities of Change bring stakeholders together, including government officials. CoCs provide a good mechanism for improvement of good governance in a country.

Cordaid



Royal Tropical Institute
KIT Development Policy & Practice

Cordaid
P.O Box 16440
2500 BK The Hague
The Netherlands

0031 70 3136300
www.cordaid.com
info@cordaid.nl

